FILED
JUN 14 1993
OFFICE OF THE CLERK

No. 92-1813

IN THE SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1992

FHP, INC.,
Petitioner,

v.

ADA SOLORZANO, AMERICA RODRIGUEZ, and DOLORES MORALES, in their individual capacities and for the general public,
Respondents.

BRIEF IN OPPOSITION TO PETITION FOR WRIT OF CERTIORARI

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QUESTION PRESENTED

Should this Court review the California state courts' determination that they are not deprived of the power to hear an action against an HMO for fraud and unfair business practices under state law merely because certain aspects of that HMO's marketing practices are also regulated under the federal Medicare Act.

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BRIEF IN OPPOSITION TO PETITION FOR WRIT OF CERTIORARI

Respondents Ada Solorzano, America Rodriguez and Dolores Morales hereby submit their brief in opposition to the petition for a writ of certiorari, which seeks review of the decision of the California Court of Appeal in this case. (Pet. App. 1) That decision is reported at 10 Cal. App. 4th 1135 (1992); modified, 11 Cal. App. 4th 443d (1992). Review was denied by the California Supreme Court on February 11, 1993. (Pet. App. 41)

SUMMARY OF ARGUMENT

After an exhaustive analysis of the governing statutes, regulations and case law, the California Court of Appeal concluded that "Congress clearly recognized the need for state and local assistance in regulating the marketing of HMOs and other supplemental health care packages to the elderly and disabled and, quite the opposite of intending preemption, appears to have intended a call to the states (and private parties) for all the help it can get." (Pet. App. 21) Accepting FHP's position, on the other hand, would prevent the State of California from regulating Medi-Cal providers like FHP which also are Medicare providers and would strip from the California courts the power to hear traditional fraud claims, all because some of the defendant's activities are regulated by the federal government.[1]

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1 The California Medical Assistance Program ("Medi-Cal") is a joint federal-state program authorized under Title XIX of the SSA [Medicaid] and administered by California to pay for medical care of, among other, indigent elderly persons.
FOOTNOTE 1 CONTINUED ON NEXT PAGE

FHP has presented no adequate reason why this Court should grant review. The federal circuits are not divided on this issue: every United States Court of Appeals that has examined the question whether Medicare regulations preempt traditional state law remedies has found no preemption. No important, unsettled federal questions are presented: rather the California Court of Appeal in this case merely applied well-settled preemption principles.

FOOTNOTE 1 CONTINUED FROM PREVIOUS PAGE
42 U.S.C. §1396 et seq. (West 1983 & Supp. 1992). Medicare is the federal insurance program administered by HCFA and authorized by Title XVIII of the Social Security Act ("SSA") to pay for medical care of persons 65 and older. 42 U.S.C. §1395 et seq. (West 1983 & West Supp. 1991). FHP's description of the benefits enjoyed by Medicare recipients when they join an HMO is inaccurate because it ignores the additional benefits that Medi-Cal recipients such as plaintiffs already receive. (Pet. 4-6) In fact, recipients of both Medi-Cal and Medicare benefit very little from joining an HMO.

STATEMENT OF THE CASE

On June 26, 1991, plaintiffs Ada Solorzano, Dolores Morales and America Rodriguez, who are elderly, indigent, Spanish-speaking women, filed a complaint against FHP for fraud and unlawful and unfair business practices. The complaint alleges that FHP sales agents induced the plaintiffs to enroll in FHP's "Senior Plan" by falsely assuring them that they could continue to be treated by their present physicians for a nominal additional charge. In some cases, these agents also falsely stated that the federal government was seeking to cut back its use of private doctors and that FHP was affiliated with California's Medi-Cal program.

Based upon these fraudulent misrepresentations, each plaintiff enrolled in FHP and assigned to that company their Medicare and Medi-Cal benefits. To their dismay, they were then turned away by their doctors, or presented with bills they could not pay.

Plaintiffs seek injunctive relief under the California Business & Professions Code §§ 17200 and 17500 to enjoin FHP's unlawful and unfair business practices and violations of California Medi-Cal law. In addition, plaintiffs seek compensation and punitive damages for fraud and intentional infliction of emotional distress. FHP demurred to plaintiffs' First Amended Complaint, moved to strike the punitive damages claims and moved for judgment on the pleadings on the causes of action seeking injunctive relief -- arguing that federal law preempted these causes of action.

The California Court of Appeal granted plaintiffs' petition for a writ of mandate, rejecting FHP's preemption theory after a through review of the record. The California Supreme Court denied review in an unpublished memorandum opinion. (Pet. App. 41)

REASONS WHY THE WRIT SHOULD BE DENIED

FHP's Petition fails to meet any of the criteria for review set forth in Supreme Court Rule 10. The California

Court of Appeal's decision is not inconsistent with any other authority, nor does it address any unsettled important questions of law. Rather, the Court of Appeal applied well-settled preemption analysis to arrive at a result that allows the existing scheme of concurrent regulation of health care organizations to continue as it has traditionally operated. Granting review would not serve any of the purposes of Rule 10, but would merely allow FHP another chance to argue its untenable theories.

A. There Is No Conflict Among The Circuits Or With Any Other State Court Decisions.

As the Court of Appeal noted, "the courts have consistently rejected arguments that other parts of the federal Medicare regulations are sufficiently pervasive to preclude state regulation." (Pet. App. 17) Three federal circuits have addressed this issue and they reached the same conclusion as the California Court of Appeal. In Medical Society of the State of New York v.

Cuomo, 976 F.2d 812 (2d Cir. 1992), Pennsylvania Medical Society v. Marconis, 942 F.2d 842 (3d Cir. 1991), and Massachusetts Medical Society v. Dukakis, 815 F.2d 790 (1st Cir. 1987), cert. denied, 484 U.S. 896 (1987), the courts held that there was no preemption of the states' ability to regulate balance billing of Medicare recipients.[2] No preemption was found in those cases even though they involved an aspect of the Medicare program which is much more heavily regulated than the area of marketing. (Pet. App. 17, n.12)

FHP also cannot cite any other state court decision inconsistent with the decision of the California Court of Appeal in this case.

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2 Balance billing occurs because Medicare reimburses the patient 80% of the reasonable charge of the doctor. The doctor then looks to the patient for the balance of his/her fee.

B. The Petition Raises No Important Or Unsettled Federal Question.

1. Congressional Intent Is The Touchstone Of Preemption.

As the Court of Appeal recognized, "Congressional intent, whether explicitly stated or implicitly contained in the structure or purpose of a statute, determines whether a law of the United States preempts regulation by the states of the same subject matter." (Pet. App. 4, citing Cipollone v. Liggett Group, Inc., 505 U.S. ___, 112 S.Ct. 2608, 2617 (1992); Jones v. Rath Packing Co., 430 U.S. 519, 525 (1977)).

All parties agreed, and the Court of Appeal found, that this is not a case of express preemption. (Pet. App. 5, 9) Therefore, this action could only be found to be preempted (1) if state court adjudication of this claim actually conflicts with federal law, or (2) if federal law so thoroughly occupies a legislative field by a pervasive and complex regulatory system as to make reasonable the inference that Congress

left no room for the states to supplement it. (Pet. App. 4, 5)

FHP's burden of proving preemption, as the Court of Appeal also noted, becomes even greater where the field in question is "historically within the police powers of the states . . ." (Id.) Here, there is no question that the health care field is one which the states have traditionally regulated. Pennsylvania Medical Society, 942 F.2d at 846. (Pet. App. 5) The state courts are also, of course, well-accustomed to hearing and deciding cases of deceptive and unfair business practices.

2. Congress Intended No Preemption Of State Regulation Of HMO Marketing Practices.

The California Court of Appeal correctly identified that the only evidence of Congressional intent in the Medicare Act, 42 U.S.C. § 1395 et seq., favors joint federal/state oversight of HMOs. (Pet. App. 18) The opening

provision of the Medicare Act states that:

> Nothing in this subchapter shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or . . . over . . . [a] person providing health services; or to exercise any supervision or control <u>over the administration or operation of any such institution</u>, agency or person.

42 U.S.C. § 1395 (emphasis added). As the Court of Appeal recognized, the Medicare Act expresses "an intent to minimize federal intrusion into the administration of the Medicare program." (Pet. App. 17)

HCFA has followed this lead and prescribed procedures and conditions under which an HMO may inform and enroll Medicare beneficiaries. Far from asserting any intent to act exclusively, this agency has unequivocally recognized the power of the states to regulate the marketing activities of HMOs. In its publication entitled "Health Maintenance

Organization/Competitive Medical Plan Manual," HCFA states in clear language to HMOs like FHP that:

> Your HMO/CMP member rules cannot conflict with Medicare rules. You must also meet all state (and local) requirements for marketing activities (e.g. state licensure and in some states, review of marketing material) (¶ 2201; Pet. App. 13)(emphasis added)

The Court of Appeal correctly observed that "HCFA has construed the federal law in the only logical fashion -- against preemption and in favor of joint regulation with the states, to ensure that the elderly and infirm are not victimized by deceptive advertising practices." (Pet. App. 18)

HCFA's directive is more than just an "informal guideline";[3] it is the mandate of the federal agency charged with administering the Medicare program signaling that it does not hold exclusive rein over this area.

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3 (Pet. at 27)

The Executive Branch in general has expressed the view that preemption should be asserted only in exceptionally clear circumstances. In Executive Order No. 12612, entitled "Federalism," the policy is stated that "federal action limiting the policymaking discretion of the States should be taken only where constitutional authority for the action is clear and certain and the national activity is necessitated by the presence of a problem of national scope." In addition, preemption should not be asserted by any federal agency unless the statute contains "an express preemption provision or some other firm and palpable evidence compelling the conclusion that the Congress intended preemption of State law."

Consequently, it is disingenuous for FHP to contend that the federal interest is being harmed by the plaintiffs' request for injunctive relief. The federal interest is reflected in this Executive Order, the HCFA Manual and the Medicare Act. As the Court of Appeal found, none of this legislation or

regulation evinces any intent to preempt state regulation, and in fact demonstrates the opposite.

3. Medicare Regulations On Recruiting New Members Are Not Pervasive.

The Court of Appeal found that "the statutes and regulations [concerning the marketing of health care plans] are neither extensive nor particularly detailed and there is ample room for the states to fill in gaps in the regulatory scheme." (Pet. App. 16-17) Not only have three federal circuits already rejected preemption of state action by the Medicare Act in an area much more heavily regulated than the area of marketing,[4] but the marketing regulations that FHP contends are so extensive and detailed amount to a mere 10 pages. Moreover, FHP cites practically all the relevant provisions in its brief. (Pet. 18-19) Beyond requiring advance

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4 Massachusettes Medical Society, 815 F.2d 790; Pennsylvania Medical Society, 942 F.2d 842; Medical Society of the State of New York, 976 F.2d 812.

approval of promotional material and forbidding misrepresentations in general terms, these regulations provide virtually no guidance as to the actions that would be considered false or misleading, or the manner in which face-to-face or telephone solicitation may be conducted. Nor do these regulations provide for compensatory damages, punitive damages or injunctive relief.

As the California Court of Appeal also found here, even if the regulations in question here were viewed as "comprehensive," no finding of preemption would be appropriate. (Pet. App. 17) As this Court has held, "[t]o infer preemption whenever an agency deals with a problem comprehensively is virtually tantamount to saying that whenever a federal agency decides to step into a field its regulations will be exclusive." Hillsborough County v. Automated Medical Lab. Inc., 471 U.S. 707, 717 (1985).[5] As

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5 In Hillsborough, this Court held that, unless Congress has clearly indicated a contrary intent, the FDA's statement that its regulations were not intended to preempt state regulation

FOOTNOTE 5 CONTINUED ON NEXT PAGE

the Court of Appeal correctly observed, "when Congress intends to fully occupy a field to the exclusion of state regulation, it knows how to do so." (Pet. App. 18) FHP's claim that a few pages of regulation equals preemption completely misunderstands the role of an agency in a modern society.

Finally, FHP's comments regarding the federal government's interest in encouraging HMOs to contract with the government to provide services to Medicare beneficiaries also miss the point. Nowhere has Congress stated that such purported efficiencies should come at the expense of the Medicare beneficiaries themselves. It is clearly not in anyone's interest that HMOs be allowed to engage in fraudulent marketing tactics under the guise of saving costs for the federal government.

FOOTNOTE 5 CONTINUED FROM PREVIOUS PAGE should be regarded as dispositive. Id. at 714. The same effect should be accorded HCFA's statement that its regulations are not intended to be exclusive.

4. There Is No Conflict Between Federal and State Regulation.

For a conflict between federal and state law to result in preemption, the conflict must be such that "compliance with both federal and state regulations is a physical impossibility," Florida Avocado Growers v. Paul, 373 U.S. 132, 142-143 (1963)(emphasis added), or when state law "stands as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress." Hines v. Davidowitz, 312 U.S. 52, 67 (1941); see also Hillsborough, 471 U.S. at 714-716.

Neither condition is present here. Far from conflicting, the state and federal regulations at issue here are nearly identical. As the Court of Appeal stated, "[i]ndeed, the federal and state regulatory schemes are strikingly similar, consistently parallel systems working together to prevent the very practices Plaintiffs allege -- misrepresentations about the lock-in provisions of FHP's Senior Plan." (Pet. App. 20)

FHP never mentions the state laws and regulations governing HMOs that it apparently believes should be preempted: California Welfare and Institutions Code Section 14409 (a) and (c), which bars prepaid health plans and their representatives from misrepresenting themselves, their plans, or the Medi-Cal program; California Health and Safety Code § 1360, which bars health care service plans from using advertising or solicitation which is untrue or misleading; and Title 22, California Code of Regulations, Section 53406, which bars misrepresentations by marketing representatives. (Appendix A attached hereto)

There being no conflict between the state and federal statutes regulating HMOs' marketing practices, FHP is compelled to resort to the novel argument that HCFA and a state court might reach different conclusions on whether FHP has committed fraud, and that even the possibility of disparate findings of fact somehow provides the basis for preemption. Yet, as the Court of Appeal

recognized, "we cannot take seriously FHP's claim that an injunction might prevent the continued marketing of its Senior Plan in its present form. To justify an injunction restraining sales of that plan, the trial court would have to be satisfied the plan itself was misleading, deceptive or otherwise prohibited. If it is, it should be enjoined. If it isn't, it won't be". (Pet. App. 20, n.14)

Even if a state court might find fraud, while HCFA might not, this potential inconsistency in factual adjudication does not lead to preemption. FHP does not cite a shred of authority for the proposition that the possibility of inconsistent factual findings by bodies of overlapping jurisdiction suffices to establish preemption. It is well established that a state's imposition of a stiffer penalty or a higher standard of care than mandated by federal law does not result in preemption. States are entitled to impose higher standards or greater liability then may be permitted by

federal law. California v. ARC America Corp., 490 U.S. 93, 105 (1989)("state causes of action are not preempted solely because they impose liability over and above that authorized by federal law"). (Pet. App. 19)

Furthermore, FHP's argument that a HCFA investigation conducted over a year ago exempts the company from a state court action has been expressly rejected by this Court. (Pet. at 20-23) In Silkwood v. Kerr-McGee Corp., 464 U.S. 238 (1984), the federal Nuclear Regulatory Commission had conducted an investigation of the Silkwood contamination. It found only minor violations by the company. Id. at 262 (Blackmun, J., dissenting). However, just like the Court of Appeal in this case, this Court did not find that that investigation prevented a state court from having jurisdiction over a personal injury lawsuit against the company. Nor did it prevent the state court from imposing a $10 million punitive damages judgment against the company. This award was allowed to stand despite the fact

that nuclear power plants are normally outside state regulation. As here, there was no evidence of Congress's intent to preempt such actions.[6] Likewise, just because HCFA looked at FHP's marketing practices over a year ago does not exempt FHP from this lawsuit.[7]

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6 FHP erroneously cites Silkwood as support for its contention that regulatory actions by private plaintiffs may be preempted while state actions are not. That case, as well as English v. General Electric Co., 110 S. Ct. 2270, 2278-2279 (1990), reach the opposite conclusion. In both cases, this Court found that Congress could preempt certain fields -- promulgation of safety regulations by states -- but allow private parties to sue if state law was breached by a federally-regulated entity. FHP has cited no case holding that an action by an individual was preempted where the same action brought by a state would not have been preempted. (Pet. App. 9, n. 7)

7 It should be noted that, contrary to FHP's suggestions, HCFA by no means granted FHP a clean bill of health after its review. Rather, it was only because FHP apparently agreed to extensive modifications in its sales practices that HCFA determined that it could still market its senior plan. However, HCFA did find evidence of improper marketing practices at FHP. (Pet. App. 61-62)

5. Review Of This Interlocutory Decision Would Be Premature.

Finally, the interlocutory nature of the California Court of Appeal's decision is additional and sufficient grounds, on its own, for denial of a writ. See Hamilton-Brown Shoe Co. v. Wolf Bros. & Co., 240 U.S. 251, 258 (1916); American Construction Co. v. Jacksonville, T. & K.R. Co., 148 U.S. 372, 384 (1893). Pre-trial review is particularly unwarranted here because the record is incomplete and because the trial court's ultimate decision on the merits may dispose of this issue entirely.

FHP's argument depends in large part on a December 20, 1991 letter from HCFA to FHP, which FHP contends is a summary of HCFA's ultimate findings regarding its investigation of FHP. FHP relies on that letter to argue that if the trial court decides to issue an injunction, the injunction would "conflict" with HCFA's findings. FHP attached a copy of the letter to its Petition, although the letter is not part of the record and was therefore not considered by the courts

below[8] (Pet. App. 61-62; FHP's response to plaintiffs' second request for production of documents). Even if the letter were part of the record, however, review would be premature because the trial court may not even issue an injunction or might issue an injunction that does not conflict with federal law or with any HCFA order. In fact, given that plaintiffs merely seek to enjoin FHP from committing fraud, it is hard to imagine how a state court injunction could even present this type of conflict. This "potential conflict" argument would then be completely baseless, and review by this Court would be unnecessary.

Thus, even if this Court is inclined to grant review, it should wait until after a trial on the merits, when the record is complete and the trial court has made a final determination.

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8 In fact, FHP refused to produce this letter to plaintiffs in response to plaintiffs' discovery requests. This is the only evidence FHP has produced regarding HCFA's findings.

CONCLUSION

FHP's petition for certiorari should be denied.

Dated: June 14, 1993

Respectfully submitted,

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APPENDIX A

California Welfare & Institutions Code § 14409. Misrepresentation; penalties; misdemeanor

(a) No prepaid health plan, marketing representative, or marketing organization shall in any manner misrepresent themselves, the plans they represent or the Medi-Cal program. Violations of this section shall include, but are not limited to:

(1) False or misleading claims that marketing representatives are employees or representatives of the state, county, or anyone other than the prepaid health plan or the organization by whom they are reimbursed.

(2) False or misleading claims that the prepaid health plan is recommended or endorsed by any state or county agency, or by any other organization which has not certified its endorsement in writing to the prepaid health plan.

(3) False or misleading claims that the state or county recommends that a Medi-Cal beneficiary enroll in a prepaid health plan.

(4) Claims that a Medi-Cal beneficiary will lose his benefits under the Medi-Cal program or any other health or welfare benefits to which he is legally entitled, if he does not enroll in a prepaid health plan.

(c) Any marketing representative who violates subdivision (a) while engaged in door-to-door solicitation is guilty of a misdemeanor, and shall be subject to a fine of five hundred dollars ($500) or imprisonment in the county jail for six months, or both.

California Health & Safety Code
§1360. Untrue or misleading advertising or solicitation

(a) No plan, solicitor, solicitor firm, or representative shall use or permit the use of any advertising or solicitation which is untrue or misleading, or any form of evidence of coverage which is deceptive. For purposes of this article:

(1) A written or printed statement or item of information shall be deemed untrue if it does not conform to fact in any respect which is, or may be significant to an enrollee or subscriber, or potential enrollee or subscriber in a plan.

(2) A written or printed statement or item of information shall be deemed misleading whether or not it may be literally true, if, in the total context in which the statement is made or such item of information is communicated, such statement or item of information may be understood by a person not possessing special knowledge regarding health care coverage, as indicating any benefit or advantage, or the absence of any exclusion, limitation, or disadvantage of possible significance to an enrollee, or

potential enrollee or subscriber, in a plan, and such is not the case.

(3) An evidence of coverage shall be deemed to be deceptive if the evidence of coverage taken as a whole and with consideration given to typography and format, as well as language, shall be such as to cause a reasonable person, not possessing special knowledge of plans, and evidence of coverage therefor to expect benefits, service charges, or other advantages which the evidence of coverage does not provide or which the plan issuing such coverage or evidence of coverage does not regularly make available to enrollees or subscribers covered under such evidence of coverage.

(b) No plan, or solicitor, or representative shall use or permit the use of any verbal statement which is untrue, misleading, or deceptive or make any representations about coverage offered by the plan or its cost that does not conform to fact. All verbal statements are to be held to the same standards as those for printed matter provided in subdivision (a).

Title 22 California Code of Regulations
§ 53406. Misrepresentation

(a) Marketing representatives shall not misrepresent themselves, the plan or the Medi-Cal program through false advertising, false statements or in any other manner in order to induce Medi-Cal beneficiaries to enroll in the plan.

(b) Violations of this section shall include, but are not limited to, false or misleading claims, inferences or representations that:

(1) Marketing representatives are employees or representatives of the State or county or anyone other than the plan or the marketing organization by which they are reimbursed.

(2) The plan is recommended or endorsed by any state agency or county agency or any other organization which has not certified its endorsement in writing to the plan.

(3) The State or county recommends that a Medi-Cal beneficiary enroll in a plan.

(4) A Medi-Cal beneficiary will lose benefits under the Medi-Cal program or any other health or welfare benefits to which he is legally entitled if the beneficiary does not enroll in a plan.